

# **Primary Care Reform in Canada:**

## **An Overview**

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by

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# Primary Care Reform in Canada:

## An Overview

### 1. Introduction

Imagine the health care system that lies behind a typical encounter with a family physician in a Canadian city. The family physician or general practitioner (GP) is the first point of contact at the front line of a system that includes the physician's practice (solo or with other doctors in the office) and the local network of health care sectors including other primary care practices, long-term care, home care, community care, public health, and acute care in hospitals. These sectors, in turn, usually operate within a regional health authority also responsible for hospitals, health centres and some long-term care facilities. Regional health authorities establish the priorities for provision of health care in the region, set standards of quality and accessibility for the delivery of health services, allocate resources, and monitor and evaluate services.

Such regional authorities are responsible to provincial government ministries of health, which set overarching policies for the planning, administration, and delivery of services and are responsible for the overall workings of the system in the province. Provincial governments provide the majority of funds to the health care system from tax dollars and allocate resources to the regions. Finally, the federal government also has a role in the health care system through its spending power, legislation including the Canada Health Act (CHA),<sup>1</sup> and its responsibility for management of health services on federal lands and Indian reserves, and for funding health care services for particular groups including military personnel. Provincial governments must ensure that health care services fit the broad principles laid out in the CHA in order to receive their respective share of federal funds for health care. The federal and provincial governments also fund research in health and the delivery of health services.

Given the complexity of the system, it is not surprising that there are a number of "hot spots" where debates occur about the optimal ways to fund and deliver health care. The public debate in Canada, and especially now in Alberta, is focused on the opportunities and costs associated with opening up more space in the acute care sector for private, for-profit organizations to contract with regional health authorities to provide services. This debate touches on such issues as how to establish and maintain reasonable access and waiting lists for services, the role of competition in the health care system, and the likelihood that support for the public system will erode with the introduction of private providers.

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Analyses and debate here relate to the very principles that support the system.

Advocates of a role for private actors in the system suggest that such changes would improve the efficiency of the system and cut waiting time for care. Opponents argue that there is insufficient evidence to support the change and, furthermore, that it would undermine the principles of accountability and of universal access to services for all individuals, regardless of their financial means, which characterize the public system. They also point to evidence that shows administrative efficiency is higher, with lower costs, in public systems.

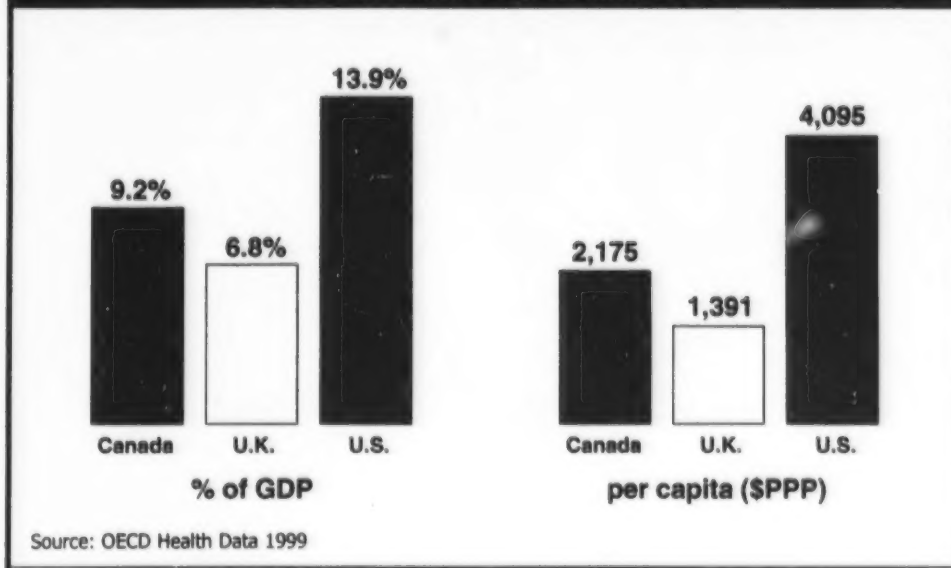
Individuals, community leaders, physicians, nurses, other health care providers, officials, and politicians rightfully contribute to this debate, which has taken centre stage in the newspapers, in legislatures, and in daily conversations.

At the same time, many researchers and analysts are discussing dimensions of health care reform which are not concerned so much with the framework of principles that supports the system as with changes to the structures and processes of the system – for example, funding mechanisms, physician payment methods and service delivery models. Canadians are not alone in this pursuit. There has been a tremendous amount of research generated about how to reform the funding and delivery of health care in national systems. Regardless of the differences in principles about whether health care is a public or private good, governments and citizens in many countries are confronted with a number of shared challenges to their health care systems. The solutions to these challenges, while varied, are focused on common elements such as funding, physician payment, delivery of services, administration and governance. One of the sectors that has figured most prominently in health care reform is *primary health care*.

Based on a review of the literature, this study is designed to move from a general discussion of the challenges confronting health care systems of western, industrialized countries, using evidence from the United States (US), the United Kingdom (UK), and Canada, to a more specific presentation of key elements and issues in primary care reform with an outline of a project now underway in Calgary. The report shows that primary care reform is an essential feature in the three health care systems under study. Finally, the initiatives in the Canadian provinces in the area of primary health care are presented. This report serves as a primer on the issues in primary care reform and identifies questions about the process of reform itself that future research could address.

*The report shows that primary care reform is an essential feature in the three health care systems under study.*

Figure 1  
Total Expenditures on Health, 1997



## 2. Different Systems, Common Themes: Issues in Health Care in Canada, the UK, and the US

A number of shared challenges confront the western industrialized countries, leading to the demand for reform of health care systems to contain spending, to respond to emerging population health needs – in particular the rising proportion of elderly persons in the population – and to manage the opportunities and costs posed by new technologies. There is an obvious economic dimension to these challenges. Health care consumes a significant amount of national expenditures in the advanced western democracies (see Figure 1). Beyond economic considerations, there are also other important themes that emerge in discussion of the current issues in national health care systems. As the following section shows, analyses of the Canadian, UK and US systems highlight such themes as: the relationship between public values (e.g., universality) and health care; availability of services; reconciliation of overarching objectives including high quality of patient care and cost-effectiveness; the role of competition in health systems; and, finally, the recognition that there are multiple determinants of health in addition to health care.

### 2.1 The Ethical Foundations of Health Care Systems

The development and operation of health systems are both informed by and reflect ethical principles. Most analyses consider the ethical foundations of health care systems, in

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addition to their respective economic, social, political and cultural environments, in order to understand the development and evolution of the system. The central distinction in analyses of the values that underlie health systems is between private and public systems.

The American system is the prototype for a predominantly privately-funded system in which voluntary, employment based private health care plans are the main instrument for health insurance coverage. For instance, about two-thirds of the non-elderly population in the US are covered by work-related insurance programs, while 10% of the population pays for non-employment based private health insurance and about 12% of the population is covered by the public health insurance programs, Medicare and Medicaid, including the elderly and disabled under Medicare and a proportion of the low-income population under Medicaid. Dillabough (1998, 78) characterizes the system as one informed by the pre-eminent public value of individual choice based on individual interests and according to individual means. In the United States, the health care system reflects an emphasis on the libertarian conceptualization of distributive justice. It focuses on the predominance of the market in the distribution of health care services and makes individuals primarily responsible for generating their ability to pay through employment-based private health care plans, non-employment based private health insurance or out-of-pocket payments. However, about 43 million Americans do not have health care insurance and the number is growing annually. Advocates of the American system nevertheless argue that the predominantly private system generates multiple sources of finance, enables competition, and provides consumers with the opportunity to spend their private resources to gain access to health care. The distribution of health care services, then, is primarily determined by market principles.

The Canadian health care system is informed by a more egalitarian than individualistic approach. In principle, this means that Canadians have universal access to a comprehensive package of necessary medical services, funded by tax dollars. Private insurance can be purchased to cover care not deemed essential in the public system, but the public system ensures that the basic health needs of citizens are met. Health care as a public good is considered important both for the well-being of the population and for the productivity of the society. Thus, the central difference between approaches to health care in the US and Canadian systems is that Canadians are universally covered by public insurance for a core list of preventive, curative and emergency care services administered by provincial health plans.

The National Health System (NHS) is the central publicly-funded vehicle for the delivery of health care in the UK. Publicly provided services include primary care and hospital care, and extensive subsidization of drug costs, so universality and accessibility are important

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values reflected in the system. A much smaller, privately-funded, for-profit sector offers services to people who can afford to pay for faster access to services through private insurance schemes. Specialists provide most of the private care, supplementing their work in the public system, using privately-funded wards in public hospitals or in private hospitals. About 11% of Britons have private insurance and about half of them receive insurance as an employment benefit.

In all three countries, there is evidence of the relationship between public values and the nature of health care policy. Canada provides an excellent case study. One illustration of many is a summary report of research on Canadian values related to health care commissioned by the National Forum on Health. The study makes the case that health care holds a place in the Canadian construct of citizenship, that most profound definition of the nature of community, of belonging, and of the relationships between citizens, the state and society (Ekos Research Associates 1997). The report notes: "There is a broad consensus that the Canadian health care system is a collective accomplishment, a source of pride and a symbol of core Canadian values. The values of equality, access and compassion are salient...."<sup>2</sup> Similarly, there is discussion of the importance of ethical principles in a recent analysis of reforms to the NHS in the UK, where a number of significant system-wide reforms have been made over the last decade. Beginning in 1989, important changes were made to the financing and organization of services through the introduction of an "internal market," emphasizing competition for provision of services to patients. However, in their assessment of these changes, Marek Koperski and Jonathan E. Rodnick (1999, 143) argue that, amongst other values, the culture of equity for all patients was not sufficiently recognized in the reforms. The reforms did not fully succeed as planned for a number of reasons, including administrative and financial factors, but also because the changes did not recognize the vitality of important social values.

This brief discussion does not do justice to the normative debate about the nature of health care and whether it should be conceived as a public or private good. Rather, it is intended to illustrate the argument that values play a significant role in the development and evolution of national health care systems.

## **2.2 The Supply of Health Care Services**

The advanced industrialized countries are in a privileged position regarding standards of treatment and access to cutting-edge technology for prevention, diagnosis, and treatment of illness and disease. Of course, these advantages are expensive. Indeed, it is important to differentiate between health care *costs* and health care *spending*.<sup>3</sup> Increases in health care spending (as opposed to costs) in all countries in recent decades are often related to

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improvements in "prices, outcomes, side effects, recovery time" and to the cost effectiveness of many procedures including angioplasty, hip and knee replacements and non-invasive diagnostic procedures that were previously neither cost-effective nor widely available (Morris, 1999, 87). As Charles R. Morris (1999, 90) writes, "New technology has the same effect on health care that it had on John D. Rockefeller's oil industry, on Henry Ford's Model T and on today's cell phones: it decreases costs and expands markets." The fact is that almost all improvements in health care increase spending over the long-term because procedures become more cost-effective to perform, often with less recovery time, leading to increased demand for them by physicians and patients.

More than ever, it seems, contemporary health systems face the age-old policy problem of how to optimize the allocation of finite resources. This necessity for making choices about spending is inherent in all health care systems. For instance, Maynard and Bloor describe the situation in the UK as one in which the gap between what medical technology can deliver and the affordability of costs has become so great that "health care decisions inevitably involve economics" (1998, 427). Although a shared problem, there is an important distinction between private and public systems with regard to the rationing of services. In privately-funded systems, rationing takes place through the market mechanism of ability to pay; in public systems, waiting lists are used to allocate services, giving priority to urgent cases (1998, 426-427).

### **2.3 Bridging the Gap: Maximizing Health Outcomes and Cost-Effectiveness**

Health policymakers are faced with the task of reconciling the objectives of maximized health outcomes and cost-effectiveness. Reforms of health systems are directed towards one or more of the following goals: efficacy, efficiency, equity and quality of the system. McManus and Thai (1998, 529) describe these goals, which relate both to the quality of care and cost-related concerns:

- efficacy describes beneficial outcomes of services for individuals and populations;
- efficiency describes the cost-effectiveness of a service relative to the resources used;
- equity describes the degree to which health services meet the perceived and measured needs of all members of the population;
- quality describes the difference between actual and desired outcomes.

These objectives are important to all actors in the health policy field, including decision-makers, analysts, and practitioners, although these actors may have competing

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perspectives on the relative weight that should be given to each. Similarly, the reconciliation of these goals is different across national systems.

## 2.4 The Question of Competition

There is significant debate over the merits of competition in health care systems. It is important to note that competition can be introduced within the publicly-financed system using incentives within public institutions. Competition has a more obvious role in a regulated, private market for health care (1995, 43). Hurley et al. (1999, 11) recognize the merits of regulated competition with a purchaser/provider split, in which health authorities purchase services from providers, for creating greater choice and responsiveness within the system. Theoretically, competition between providers for contracts with purchasers will exert pressure in favour of high-quality services delivered at the lowest possible cost. However, competition and serious fiscal pressures can lead to prioritization of economic considerations in health-care decision-making.

In addition to the debate over the virtues of a purchaser/provider split, the issue of competition arises with regard to the benefits of patient choice (and competition between providers inherent in patient choice). The theory of competition suggests that patient choice of providers will lead to high quality of service,<sup>4</sup> but it is also the case that consumers need adequate knowledge to make a meaningful judgment. In the health care field, information and the capacity to make such choices might be lacking given that many aspects of health treatment require extensive expertise (Hurley et al. 1999, 35).

### **An Internal Market for the Canadian Health Care System?**

McArthur et al. argue that the introduction of competition to the Canadian health care system through a purchaser/provider split (similar to the National Health Service in the UK) would improve efficiency and service quality. They propose the implementation of Regional Purchasing Agencies (RPAs) to purchase services on behalf of regional populations through a process of competitive bidding by providers for contracts. In the case of primary care, RPAs would allocate budgets to GP fundholders for the purchase of medical services (e.g., x-ray, lab services, home care, physiotherapy) (1996, 169). However, in their discussion of the introduction of internal markets to the NHS, Maynard and Bloor argue that there is little evidence in the UK or elsewhere that competition necessarily produces efficiency or improves quality in health care. They counsel that evaluation is critical to determining the impact of reforms on efficiency. "Competition needs to be used with caution and recognized as a means and not an end in itself" (1998, 438).

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## 2.5 Multiple Determinants of Health

Increasingly, governments, health organizations, and citizens are taking a more holistic view towards the determinants of health. J. Lavis and G. Stoddart (1999, 19) define health determinants as "factors that determine why some people are healthy and others are not." Important determinants, in addition to health care, are education, environment, income distribution, and employment and working conditions. Pran Manga (1998) writes about the increased recognition of the benefits of greater community participation in health care decision-making as well as a more appropriate allocation of resources to reflect the many determinants. Reflections of this more holistic view of health are evident in public policies as well. For instance, in the UK, reforms to the NHS undertaken by the Labour government in 1999 propose to more fully integrate health and social services. Health action zones will be established in areas of high poverty and poor health to enable multiple actors including physicians, local authorities, business representatives, and members of the community to work together to combat health problems (Korcok 1994, 143). In Canada, the Federal/Provincial/Territorial Advisory Committee on Population Health synthesized the various descriptors of health determinants to focus on the following key factors: "healthy child development, education, income and social status, employment and working conditions, social support network, physician environment, biological and genetic endowment, personal health practices and coping skills, and health services" (Lavis and Stoddart, 1999, 19). And Allan Rock, the federal Health Minister, recently discussed a "wellness agenda" that would include attention to the social and economic factors that correlate with health status (Maclean's 1999, 34).

## 3. A Common Response: Emphasis on Primary Care Reform

In light of the significant issues that challenge national health care systems, it is not surprising that a common response has been to emphasize and improve the delivery of *primary care health services* in all of the countries under study here. Primary care services comprise both the first point of contact with the health care system and the site where health promotion, illness prevention and treatment take place. The World Health Organization established the following definition of primary health care:

Primary health care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part of the country's health care system of which it is the nucleus ... It is the first level of contact of individuals, the family and community with the national health system bringing health care as close

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as possible to where people live and work and constitutes the first element of a continuing health care process. Primary Health Care addresses the main health problems in the community, providing promotive, preventative, curative supportive and rehabilitative services accordingly. (Federal/Provincial/Territorial Advisory Committee on Health Care 1995, 2)

The Canadian Medical Association (1998) describes the four essential elements of primary care (with physicians as the central providers) as the provision of first-contact care, continuity of care, coordination of care with physicians managing patients' care plans and referrals to specialists, and comprehensive care. Family physicians respond to a wide variety of health care needs, perform diagnosis and treatment, and advocate on behalf of patients. Although physicians are traditionally placed at the centre of primary health care, services are also delivered by a number of other health practitioners including nurses, nurse practitioners, psychologists, chiropractors, physiotherapists, dietitians, pharmacists, and midwives.

Primary care is important at multiple points in the health care system. It is related to planning and meeting the health needs of populations and individuals, and ensuring availability and accessibility of both primary care and appropriate referral to other services. Finally, the primary care sector is the one where other social and related health services can be closely integrated and made responsive to the many factors that determine health status.

There are a number of reasons why primary care reform has come to the fore in efforts to reform health care systems in the US, the UK, and Canada. First, a common response to the challenge of increased spending on health care has been to reduce utilization of acute care (hospital services) and emphasize care in the community, which creates increased demand on primary care services and requires physicians to take on increased responsibility for the coordination of care. Greater emphasis on community care also facilitates the move toward new models for service delivery and methods of physician payment. Manga (1998, 489) writes, "It is in areas of prevention, health promotion, primary health care services, and community-based health services where the potential for manpower substitution is greatest and most fruitful and where non-fee-for-service remuneration methods are most accepted." In light of this approach, it is not surprising that primary care physicians express concerns about a number of issues, including the increased expectations and responsibilities placed on them, changing relationships with other health care providers, and fair remuneration for their services.

In a separate but related dynamic, many primary care practitioners support changes that enable them to more effectively fulfill the mandate of the primary care model, in particular to increase resources spent on health promotion and illness prevention with patients.

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As a result of these developments, interest is high amongst policymakers and practitioners to find ways to ensure that needed services are available (e.g., support after discharge from hospital) and that there are incentives for physicians to deliver services in ways that make health care most effective and enable an optimal distribution of resources to meet population health needs. Efforts to promote and expand primary health care services have been the focus of a great deal of policy work by governments, medical associations (representing physicians), and other primary care provider groups. Research is directed to defining and evaluating the options for policy change and to implementing primary care reform pilot projects. The following sections outline the elements and issues in primary care reform.

## **4. Elements in Primary Care Reform**

Primary care reform describes efforts to develop the most effective, efficient and equitable delivery of primary care services to ensure optimal health outcomes for individuals and populations. Elements and issues that emerge in analyses and debates over primary care reform are covered in the discussion that follows.

### **4.1 Integrated Model of Service Delivery**

A central element of many reform models is integrated service delivery, with comprehensive care including health promotion, and illness prevention and treatment, in which a range of services are provided at one site, with access to services on a 24-hour, 7-day per week basis (through on-call and telephone assistance provided by physicians and nurses). Given their centrality to the system, primary care physicians and their practices are at the centre of the discussion of reform, often pictured as the hub of a wheel of integrated health services involving other practitioners within the system. Physician roles and responsibilities can include the physician as manager to purchase services (e.g., lab, x-ray) on behalf of patients.

There is a great deal of support in the literature for integrated health care in which more attention is given to developing a long-term plan for each individual's health care, with the primary care physician acting as coordinator of care (Manga 1998; Francis et al. 1997; Hurley et al. 1999; Forest et al. 1999). Francis et al. (1997, 69) described integrated health care in the following way:

With integrated health care, health professionals navigate individuals through the health care system, ensuring that they receive the care they need, at the best time, and from the most appropriate care provider. ... In doing so,

integrated health care reduces the incidence of over- or under-treatment, and expedites the individual's case through the health system.

In their review of international trends in health care reform, Marriott and Mable (1997, 1), find that one of the major developments is the integration of health care resources in order to improve efficiency and effectiveness. There are two dynamics behind integration. First, vertical integration involves the creation of one organization from elements of formerly inter-dependent sectors such as hospitals, primary care practices, home care and long-term-services. Second, horizontal integration involves merging entities within the same sector (e.g., primary care). In integrated organizational models in the national health systems, Marriott and Mable (Source 1997, 3) outline the changes in primary care, "with the general practitioner as gatekeeper to secondary services and a multidisciplinary team for rostered patients." The first stage in integration would be the evolution of independent primary care organizations funded by capitation budgets with rostered populations in place. Primary care practices could also develop managerial capacity to take on fundholding responsibilities for the purchase of specialist, hospital and other services.

Similarly, and focusing specifically on the primary care practice, Forster et. al. (1994, 1524) promote a model of primary care that overcomes the central problem of the existing system, which is that "the current model does not ensure family practice services of predictable comprehensiveness." In addition, there is a need for clearer lines of accountability within the system of actors involved in the health care system – purchasers (provincial and federal governments), providers (health professionals) and consumers (who pay through taxes and premiums). Such measures would ensure that health services are coordinated so that patients move "purposefully" through the system, avoiding duplication of services and inefficient use of professional skills.

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### **Funding and Physician Payment Mechanisms**

It is important to note the distinctions between funding mechanisms and physician payment mechanisms: "(1) funding is the way <sup>is</sup> which compensation is flowed to the 'primary care agency'; (2) payments are how the individual providers are compensated" (Barnes 1997, 53). In a fee-for-service system, the medical care budget is allocated among providers based on the volume and type of services provided (set by a fee schedule). Capitation systems allocate funds to organizations using formulae which reflect the size and characteristics of the population. The organizations are then responsible for providing all necessary services for the defined population. The organizations and their physicians establish one or more physician-payment options, including salary, fee-for-service, or monthly payments based on the practice roster.

Implementing the most effective and fair funding remuneration mechanisms to ensure incentives are in place for the delivery of desired services is a central prescription in primary reform proposals.

Table 1: Funding Methods in Health Systems

Funding Method*	Unit of Payment
Fee-For-Service	Individual service listed in the fee schedule.
Capitation	All defined health care needs for an enrolled population for a defined period of time.
Diagnosis-Based Payment	Acute event.
Line Budgets	Individual health care programs.
Global Budgets	All services and activities funded through the budget.
*As one moves from fee-for-service to global budgets, the extent of prospective payments increases. Source: Hurley et al. 1999, 49-50.	

#### 4.2 Alternative Funding and Payment Plans

Implementing the most effective and fair funding remuneration mechanisms to ensure incentives are in place for the delivery of desired services is a central prescription in primary reform proposals. There are a number of themes related to the issues of funding and physician payment. The most general objective is to ensure that needed services are delivered in the most cost-effective way possible. The challenges are to implement and evaluate the optimal characteristics for various funding and payment mechanisms in order to understand how new mechanisms act as incentives. As well, support from health care providers, in particular physicians, hinges on ensuring that remuneration fairly reflects the range of responsibilities undertaken by physicians.

As Table 2 shows, there are a number of primary-care funding and physician payment mechanisms. The following discussion focuses on the two mechanisms most relevant for primary care reform: capitation rather than traditional fee-for-service funding and payment mechanisms. There is a complex array of factors to consider. Capitation is a population-based funding mechanism (it goes hand-in-hand with rostering of patients), and provides greater capacity for the planning of funding and service delivery, taking into account such population characteristics as age, sex, health risks and even socio-economic status. Capitation funding can be used as a global system of funding for all GP services, for a subset of primary care services or for all primary care services, including nursing, optometry, midwifery and chiropractic care (Barnes 1997, 53). Furthermore, it is generally accepted that capitation payments bring incentives for providers and patients to use resources efficiently in illness prevention and treatment.

Capitation funding might be expected to influence the quality of care through two avenues: (1) by influencing individual treatment decisions of individual

**Table 2:**  
**Physician Compensation Methods: Adverse and Beneficial Incentives  
in Regulated Private Sector or Public Health Systems**

Physician Compensation Mechanism and Incentive Structure	Examples
<p><b>Fee-For-Service (FFS):</b> Physicians submit claims for individual services to patients based on a fee schedule. The fee schedule focuses on treatment-oriented care, reducing incentives for delivering health promotion and illness prevention services. There is an incentive to see patients and provide care (productivity). Unfettered fee-for-service promotes an excessive use of services.</p>	<p>Most primary care physicians in Canada are paid by fee-for-service. In Canada, provinces have set caps on annual physician expenditures. In the US, some Independent Practice Association HMOs have established incentives to stay within utilization targets.</p>
<p><b>Reformed Fee-For-Service:</b> Physicians charge up to an amount equal to that payable under capitation, given the size and composition of the patient roster. Within this budget, physicians are paid on a fee-for-service basis. Services including case conferences, home care supervision and preventive care services are remunerated, in addition to the regular fee codes. The model enables the introduction of population-based funding while retaining the familiarity and flexibility of FFS, incentives for productivity, and predictability in costs for the payer.</p>	<p>This model of compensation was developed by the Ontario Medical Association. In primary care organizations with capitated funding (e.g., HSOs), Reformed Fee-For-Service is one physician payment option.</p>
<p><b>Global Capitation:</b> Providers are paid a periodic fixed amount per insured person to finance the costs of a defined package of services. Encourages innovation in cost-reducing technologies, use of lower cost alternative treatments and health prevention. Negative incentives include enrollment of low-risk patients and under-provision of services. In order to overcome the incentive to under-provide, it is important to have periodic opportunities for patients to exit and enter another practice (competition).</p>	<p>Used by HSOs in Ontario, where one physician payment option is monthly payments based on the patient roster. Prepaid Group Practice HMOs in the US also use capitation funding and payment systems.</p>
<p><b>Salary, Sessionals and Grants:</b> Physicians are paid on a salaried basis from a capitated budget.</p>	<p>Examples include Community Health Centres in Canada and payment to medical and surgical specialists in the UK. Incentive payments and special allowances are used to encourage productivity, which can be lower than in other payment systems, and to address specialized care-needs for select patient groups.</p>
<p><b>Blended Funding:</b> Two or more payment mechanisms are combined for any primary care physician. The blending of payment methods enables payment to be tailored to specific types of patients or treatments and to provide a mix of incentives for the provision of care.</p>	<p>The College of Family Physicians of Canada supports this option. In the US in Prepaid Group Practice HMOs, a group or groups of physicians are paid based on capitation although some physicians may be on salary. In some Primary Care Pilot Projects in Alberta, a bundle of services is covered by a capitation model and other services are covered by fee-for-service payments. In the UK, GPs are paid using a number of options including capitation, special practice allowances and incentive payments.</p>

Source: Barnes 1997; Barnum et al. 1995; Vayda 1994.

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physicians in Canada  
are paid by  
fee-for-service.*

providers; and (2) by influencing the ways in which care is organized and delivered within an organization, affecting, for instance, the degree of integration and coordination among services. (Hurley et al. 1999, 35)

The risk with capitation funding is that the drive for efficiency will be taken to the extreme so that there is under-provision of services. Furthermore, there is the problem of "risk-selection" in which healthy patients are considered low-risk and more desirable by provider organizations. Fee-for-service carries incentives to produce (and use) services (and can encourage over-utilization of services), making it difficult to predict total annual expenditures, while capitation provides greater predictability of expenditures for a given time.

As noted, the most significant argument against capitation's benefits is that it offers incentives to "under-provide" care, that is, that services "will be of lower quality, and/or needed and appropriate services will not be provided." There are important rejoinders to these critiques. First, "professional ethics" will outweigh the incentive to under-provide care. As well, patients' capacity to choose providers should, through competition, ensure that service quality is a priority. Reform projects and demonstration sites enable evaluation of behavioural changes and the understanding of the optimal set of services that should be included in capitation funding (Hurley et al. 1999, 35).

A shift from fee-for-service funding and physician payment would lead to significant changes in primary care, and have consequences for the overall outcomes of reform. Manga writes:

moving away from fee-for-service method of paying physicians constitutes a fundamental reform of the health care systems. Incentives facing providers of care are vitally important for the assurance of both technical and allocative efficiency of the health care delivery system. All other reforms, targeted at physician services, however well-conceived work less effectively, if at all, under a fee-for-service system of paying physicians. (1998, 486)

This area of reform is one in which there is still much research to do in order to gain a systematic understanding of the effects of different funding and payment mechanisms. The success of changes is measured in such areas as support from physicians and other care providers, quality of care outcomes for patients, and increases in the overall efficiency of the health system. Barnes (1997, 53) writes that an important conclusion from the research in this area is that "there is no one right answer – that a cookie-cutter approach does not work." A number of critical factors, including the roles and responsibilities

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assumed by the primary care physician, the practice setting, and the health needs of the population, set the context for determining the most effective mechanisms for funding and physician payment in primary care.

#### **4.3 Patient Rostering**

Rostering, which involves the registration of patients with a primary care practice for all primary care, is essential for the implementation of capitated systems in which funding follows populations.<sup>5</sup> The rostering process involves inviting patients to register with a physician and his or her practice and involves a contract that outlines the respective responsibilities of the patient and physician. Practices agree to make comprehensive care available. Patients agree to seek care at the practice where they are registered, and to consult the practice for advice when they are unsure about the type of care required. These reforms are related to many primary care objectives, including "the promotion of quality care, greater continuity, encouragement of effective preventive care, consumer choice, increased accountability, better distribution of services, and more predictable costs" (Mowat 1997, 43).

Rostering enables the allocation of resources according to population needs and more effective management of health care delivery. Dickson (1997, 45) describes these benefits: "We all imagine that there would be dramatically decreased duplication of effort, that the referral process would be much more tightly controlled and that patient self-referral would stop." Furthermore, since minimum roster sizes are required, physician distribution would occur on a more efficient basis, encouraging the movement of doctors to areas of under-supply from areas of over-supply. Rostering encourages continuity of care and the development of long-term physician-patient relationships as well as health maintenance measures (Dickson 1997, 45). In Canada, the level of public support for rostering is high (80%) and about two-thirds of Canadians "approved of an arrangement stipulating that they would not go to another family physician or specialist without referral from the family physician with whom they are registered" (Hurley et al. 1999, 29).

#### **4.4 Patient Education**

Most reform proposals call for a greater focus on patient education in primary care, including an emphasis on promoting the value of developing a long-term care relationship with a physician. Education would focus on both the process of accessing care in a rostered system and on substantive measures to increase patients' knowledge about ways to improve health and prevent disease. Both dimensions of information – advice on how to navigate the system when care is needed and information on health improvement and

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maintenance – are important to the success of reforms. With regard to the first, Dickson (1997) suggests that measures to increase patient accountability are an important dimension for ensuring that rostering is effective. Although patients will retain choice regarding the physician with whom they roster, on a day-to-day basis there must be sufficient commitment to seeking care with their respective provider and some accountability mechanisms in place. He writes:

There can be no doubt that patient options will be reduced under real primary care reform, in that their ability to consume care through walk-in clinics or self-referral to specialists will be dramatically limited, and it remains to be seen whether this will be an insurmountable barrier. (46)

The College of Family Physicians of Canada (1997, 38) also recognizes elements of education for both patients and practitioners are important in order to ensure appropriate responses to primary care reforms. Indeed, Forest et al. write: "The most telling test of the transformation of our health systems would rather be their capacity to create and maintain good relations (between providers of care and citizens), 'reciprocal loyalty,' and even a common culture of health consciousness between people who need and use the services and people that provide them" (1999, 25).

#### **4.5. Information Technology Systems**

The implementation of information technology systems to generate data enables a higher degree of coordination and planning of primary care. Information systems are an expensive component of reform projects, including the costs of purchase and installation of hardware and software, training to use the equipment and programs, and long-term administrative costs. However, the potential benefits of such systems are very high. Barnes writes:

The expectation is that the development and introduction of enhanced patient management tools, such as guidelines, clinical decision support software, electronic patient records, and historical health information data linkages will improve patient care and create efficiencies for the primary care practice and eventually the health care system. (1997, 57; see also Francis et al. 1997)

#### **4.6 Rigorous Evaluation**

As noted earlier, the general goals of primary care reform (and reforms to the system generally) are to improve performance according to the criteria of equity, efficiency, effectiveness, and quality. However, while these general objectives and the more specific

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goals included in particular reform projects are known, it is difficult to monitor and evaluate primary care services, particularly in a system where patients are not rostered. Thus, primary care reform that leads to the formation of health care practices with "large rosters or populations and well-defined programs of comprehensive care" create a greater capacity to "monitor and relate outcomes to the quality of care provided by the primary care facility and the costs of their services" (Williams and Lloyd 1997, 65). As well, upgraded information technology systems enable a higher standard of monitoring and information. Finally, physicians, other practitioners, and policymakers must accept the value of the process of evaluation and the evidence generated. Although challenging to undertake, valuable research on primary care reforms has been generated for understanding the organization and delivery of primary care (William and Lloyd 1997, 66).

#### **4.7 An Example of Primary Care Reform: The Crowfoot Village Family Practice, Calgary**

The three-year primary care reform project now underway at the Crowfoot Village Family Practice (CVFP) in Calgary provides an illustration of many elements of primary care reform, including integrated service delivery, alternative funding and physician payment mechanisms, and emphasis on the goals of health promotion, illness prevention, and treatment of illness and chronic disease. The project is a joint effort of the family-practice physicians, the Alberta Medical Association, Alberta Health and Wellness and the Calgary Regional Health Authority.

The main features of the Crowfoot Village Family Practice Project are (Aufrecht 1999):

- Focus on availability and integration of services in response to the needs of the practice population: the CVFP offers access to comprehensive health care, 24-hours a day, through regular office hours including the use of a telephone triage line to direct patients to appropriate type and timing of care, an after-hours advice line staffed by a nurse, and on-call physicians. Physician services, provided by six doctors, include office visits, hospital visits, home visits and telephone consultations for assessment, treatment, and planning and coordination of patient care. Staff nurses are involved in the provision of a range of services, which gives physicians more time with ill patients. Other services are provided on site on a regular basis using systematic integration of other providers paid by the region, including diabetic care and public health nursing services.

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- **Rostering:** about 12,000 patients are enrolled with the practice for an initial 3-month commitment to attend or consult with the CVFP when care is needed. This system of rostering includes choice so that patients' "right of exit" from the primary care organization establishes an incentive for the practice to provide comprehensive and high-quality services. The practice is billed for non-emergency treatment provided to enrolled patients outside the practice. Regular patients who chose not to enroll for the project are treated on a fee-for-service basis.
- **Alternative payment plan:** the Fee-for-Comprehensive-Care payment model is an alternative payment mechanism using a capitation budget. The practice receives a monthly payment based on a per-patient payment, adjusted for age and sex, for all rostered patients. This method reflects efforts to ensure fair remuneration for physicians and provides incentives for provision of services (including health promotion and illness prevention, telephone consultations, on-call work and administrative duties) and the establishment of optimal roles and responsibilities for all health care providers. Office staff and practice nurses are paid from the budget.
- **Emphasis on the creation of long-term physician-patient relationships and patient education:** physicians monitor each patient's individual health needs and develop plans for optimizing health outcomes. Patient education includes regularly-scheduled health promotion and illness prevention sessions.
- **Use of information technology systems:** the CVFP has implemented an extensive information system to facilitate the management of patient care, including recall for regular screening and health maintenance tests, and to track quality of health outcomes. Physicians develop health management rules to establish standards of care.
- **High-quality services and cost-effective outcomes:** the goal of the project is to "offer new services such as a nurse help line, better coordination of care for patients with chronic conditions, improved information for patients about health and disease prevention, in-practice specialty services, and closer links with regional health services." Mechanisms are in place to measure and monitor patient satisfaction.

## 5. Issues in Primary Health Care Reform

In addition to defining the elements of primary health care reform, researchers raise a number of questions that are important for understanding the obstacles and opportunities inherent in reform models.

### 5.1 What are the Most Important Criteria For Measuring Reform Outcomes?

As noted in the previous section, in general, reform should promote one or more of efficiency, effectiveness, equity and quality of service. Barnes (1997, 55-58) provides the following specific criteria to determine the effectiveness of primary care reform projects, enabling practitioners and policymakers to make future decisions on primary care models:

- Do changes in funding mechanisms improve patient care? (i.e., what incentives work to ensure the provision of specific types of care?)
- Has patient access increased? (measured in terms of wait times for appointments and the distribution and availability of physicians in communities)
- Are providers more satisfied with their capacity to provide care in the most effective way, with predictable incomes, with an appropriate distribution of physicians across communities?
- Are efficiencies created? (i.e., does the funding mechanism enable integration of care and the best use of skills within a team to avoid duplication?)
- Is care more coordinated, with the primary care physician as the first point of access and coordinator of health care?
- Do the changes lead to greater integration of primary care services with physicians and other practitioners working in teams and a high proportion of patients on a roster?
- Other questions relate to the implementation and administration of reform projects so that the projects and their potential expansion are sustainable.

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## 5.2 What Forms of Governance are Important to Successful Primary Care Reform?

The systems of governance and decision-making for the primary care sector are an important element to consider when reforms are undertaken. In general, issues such as the degree of autonomy of primary care organizations in matters of budgeting, enrollment of patient populations, the degree of integration and the range of services offered are important. On a system-wide basis, a governance framework must be established to "balance the values and interests of the direct or *internal* stakeholders, like the health care providers, and the values and interests of *external* stakeholders, i.e., the community at large" are important (Forest et al. 1999). For example, as part of the most recent NHS reform package in the UK, there is a requirement for primary care practice group boards to include not only physicians but also representatives of the health authority, the community and the general public. It is expected that the level of physician accountability will increase with the new system.

## 5.3 How to Promote Evaluation and Monitoring of Outcomes and Quality Control as the Basis for Decision-Making?

As noted above, there are a number of substantive criteria for the evaluation of reform projects, but one of the central challenges is to ensure that rigorous evaluation procedures are included in reform models in the first place. Hutchison (1997) argues for a "continuous quality improvement" (CQI) framework to enable evaluation and identification of both success and shortcomings in the health care system as a whole, with effective dissemination of information. He writes: "Evaluation as CQI can help to build a health care system that over time becomes increasingly effective, efficient, and responsive to social, community and individual needs and values" (1997, 58).

The historical record of evaluation of primary care reform initiatives in Canada is poor. For example, evaluation of Community Health Centres (CHCs) and Health Service Organizations (HSOs) in Ontario did not begin until the 1990s although some of the projects began in the mid-1970s. The evaluation strategy that was long-delayed was to "provide detailed comparative evaluation of CHCs, HSOs and fee-for-service practice" (Hutchison 1997, 59). Projects in other provinces have been similarly under-evaluated in the past. The contemporary scene is more promising. For instance, there is now a study comparing HSOs and fee-for-service physicians in Ontario.

What are the reasons for lack of commitment to evaluation? Hutchison (1997) argues that the interests of stakeholders in the health system can create a kind of tunnel vision with

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## Characteristics and Procedures of Effective Evaluations

The most important characteristics of an effective evaluation are: high standards of design for the reform project itself with clear objectives against which practice can be evaluated; the simultaneous planning of the reform project and its evaluation so that the scope and resources necessary for the evaluation are known early in the project; participation of all stakeholders in the design of the evaluation and in the evaluation process; allocation of resources for evaluation at the outset of the project to ensure that it is carried out with the necessary scope so that all relevant outcomes are assessed; plans for dissemination of results to policymakers and stakeholders so that evidence is available for future decision-making (Hutchison 1997, 59-60).

failure to recognize and accept the need for effective evaluation. He writes:

Reforms and innovations are often a product of effective advocacy by proponents of a new way of doing things. These advocates are successful to the extent that they persuade decision-makers that the proposed innovation is almost certain to be successful. Under these conditions, policymakers may be blind to the possibilities of failure. (1997, 59)

Of course, there might be economic and political costs associated with "negative" evaluations (Williams and Lloyd 1997). Furthermore, the expense and effort involved in evaluation can be perceived as too costly in the short-term so that policymakers choose to underfund or not fund evaluations. Hutchison (1997, 59) calls this a "penny wise and dollar foolish view" because initial savings generated by foregoing evaluation might be offset by greater expense when problems with reforms go unrecognized in the future. As evidence, he cites an unsuccessful ambulatory care project in Ontario which cost \$53 million over the course of its 4-year operations in the early 1990s but was eventually demonstrated to be ineffective with a research program that cost \$300,000. Another issue can be attitudes of physicians toward evaluation. In order to produce high-quality evaluation, physicians and other practitioners must agree to provide information about their practices. As well, in order to be effective, policymakers and health professionals must use the information effectively. Finally, it is important to keep in mind that a long-term approach may be required for full evaluation of reform outcomes.

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### **Benefits of Evaluation from the UK Experience**

As noted in previous sections, the UK has implemented extensive reform in the NHS. The introduction of the internal market in the early 1990s carried an estimated implementation cost of more than 1 billion pounds. However, Maynard and Bloor (1998, 429) argue that "NHS reforms were introduced as a response to intense political pressure and were designed and implemented with great haste." As a consequence, the reforms were not effectively evaluated and so their advantages and disadvantages have not been clearly discerned. They conclude:

The lack of evaluation of the UK health care reforms has resulted in ignorance about costs, processes and outcomes of the internal market. Other countries implementing health care reforms should ensure that adequate evaluation mechanisms (using, at best, well designed trials or, at worst, other designs such as controlled before and after studies) to identify whether or not reforms are increasing efficiency in the delivery of health care. (1998, 433)

Maynard and Bloor conclude by reflecting on the policy context for health care reform in the UK and elsewhere, arguing that "we do not know which interventions are cost effective and we know little about the cost effectiveness of alternative ways of changing professional behaviour. ... The major deficiencies in knowledge must be addressed by research and evaluation if health care policies are to become more efficient and practitioners more accountable" (1998, 437).

### **5.4 What are the Opportunities and Barriers to Change in the Medical System?**

#### **The Role of Physicians**

There is support in the literature for the importance of enabling physicians to take a lead role in the reform process because primary care physicians play a central role in health systems, and physician attitudes and positions on reform are very important to successful outcomes. In Canada, it is likely that primary health practitioners will be at the forefront of transitions to capitation-based models of care, given their centrality to a system in which most Canadians have a primary care physician (Hurley et al. 1998, 13). In addition to practitioners, the provincial and national medical associations, in collaboration with governments at the federal, provincial and regional levels, are central to the establishment and governance of primary care reform projects.

Generally, physicians give a much higher level of support for blended funding mechanisms

than for a pure capitation model of funding. For example, the Canadian Medical Association stresses the importance of flexibility and a range of options for funding models and physician payment mechanisms. The central message is that flexibility must be built into funding and payments systems in primary care so that population health needs are met by appropriate service delivery models and providers are satisfied with methods of remuneration (Barnes 1997; Barnum et al. 1995). This conclusion is supported by Barnum et al. who conclude that mixed forms of provider payment are superior to any single method in order to minimize adverse incentives and achieve the most judicious balance between positive incentives and administrative costs (1995, 43).

### Evidence-Based Decision-Making

A potential challenge to successful reform is the difficulty in generating the evidence needed by policymakers to enable effective decision-making. In procedural terms, the task of disentangling the impact of various elements of reform models, including payment mechanisms, can be particularly difficult. Barnes concludes:

Surprisingly little is known about how to set an appropriate capitation rate and how different mechanisms of compensation for patient care and provider satisfaction actually work. This is largely because the factors we are able to take into consideration are only a small part of what actually interacts to affect health status or motivate physicians to respond in a particular way. (1997, 57)

Indeed, while much of the research on primary care reform, especially related to alternative payment mechanisms, is grounded in the discussion of payment mechanisms as incentives to encourage the provision of services at a high level of quality, Hurley et al. (1996, 14) provide an expanded model for understanding incentives in which they argue that the social and organizational context in which financial incentives are established and operate is critical to their impact. Funding reforms developed strictly according to behavioural models can fail to work as incentives in intended ways. Thus, in order to understand the effects of funding changes (and the financial incentives that are inherent in them), institutional, informational and regulatory frameworks must also be taken into account (Hurley 1996, 36).

This section has reviewed the key issues that emerge from research on primary care reform related to service delivery models, physician remuneration mechanisms, the use of information technology systems, the roles and responsibilities of physicians and other health care providers, patient behaviour, evaluation and quality assurance measures regarding outcomes, and possible barriers to reform. The following section demonstrates

*A potential challenge to successful reform is the difficulty in generating the evidence needed by policymakers to enable effective decision-making.*

the importance of primary care reform in the UK, US and Canada, and provides a guide to primary care reform in the provinces. The evidence suggests that there is a great deal of innovation and learning going on in the field of primary care reform.

### **On the Benefits of Comparative Study of Health Systems**

Most analyses of health care systems argue for a broad perspective that situates the system in the context of the health needs of the population as well as the social, economic, political and cultural traditions of the region or country. However, it is this complexity that makes comparison difficult. McManus and Thai write:

In general, the health care system of each country has developed under the influence of environmental, social, political, economic and cultural factors specific to that country. Even the OECD countries, which do have many characteristics in common, vary on important dimensions of their respective health care systems. (1998, 532)

The range of services included in health systems varies across countries and knowledge of such variations is important for the accurate comparison of expenditures. Focusing specifically on the primary care sector, there are cross-national differences (in Canada, there are also inter-provincial differences) in the bundle of services that constitute primary care and in the health care professional (physician or nurse) who delivers the various services. However, given sufficient attention to national differences and definitional variations, there is support for the value of learning through the policy and demonstration projects of other jurisdictions. For Canadians, this is true not only of other countries, including the United States, but also for inter-provincial comparisons.

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## **6. Primary Care Reform Across Three Countries: the UK, the US, and Canada**

### **6.1 Primary Care in the UK**

The primary care system in the UK is well developed and most people are registered with a GP who serves as the first point of contact in the system. GPs have a rostered practice with an average list size of 1,850 patients. GPs are self-employed but sign a contract with the NHS to provide health care to their rostered patient population in return for a mixture of fee-for-service and capitation payments (Maynard and Bloor 1998, 430-431). The majority of their salaries (60%) is paid on a capitation basis. As well, they receive payment for services, which include:

- target payments for achieving variable levels of coverage of patients on the GPs' list for childhood immunizations and preventive screening procedures, and additional payment for health promotion clinics;
- fee-for-service remuneration for minor surgery and provision of contraceptive services.

GPs typically practice in small groups and lead primary care teams that consist of their group of GPs and other health providers including home- and practice-based nurses, midwives, community nurses, psychotherapists, physiotherapists and social workers, as well as administrative staff.

There have been two waves of reform of the NHS in the last decade affecting primary care. In the 1990 reforms, health authorities, which administer health care for regionally defined populations, became "purchasers" of health care, while hospitals and community service providers (excluding GP practices but including such services as mental health and community nursing) became self-managing trusts competing for contracts from purchasers rather than funded by global budgets. GP practices were encouraged to become fundholders, applying to health authorities for budgets to purchase prescription-drugs and the services of specialists (to a total of 20% of the services) for their patient populations. Fundholders were given support to implement information technology systems to more effectively manage care, and for administrative staff. Surplus funds in fundholders' budgets could be used to enhance the practice but not as bonuses for practitioners. By 1996, about 41% of the population was registered with a fundholding GP practice, but the distribution of such practices favoured prosperous areas, where patients were perceived to benefit disproportionately from innovations and higher quality of services in primary care. Furthermore, fundholders who overspent were "bailed out" by regional health authorities, using funds initially budgeted for non-fundholders (Koperski and Rodnick 1999, 42). The central criticism of the system was fragmentation and lack of capacity to effectively plan by health authorities. Administrative costs were high. The benefits were some evidence of reduced rates for drug prescription and waiting times for hospital procedures.

In 1997, the new Labour government published the White Paper, "The New NHS," which marked another stage in the process of developing health care services in the UK. The 1997 proposals shifted the focus of the system away from competition and towards "alliances, partnerships and collaborative working between health care services, social services and the wider community" (Warne 1998,7). The purchaser/provider split remains an element of the NHS as do trusts, although there will be requirements for greater transparency and more representative boards for the operation of trusts and higher standards (i.e., statutory)

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of accountability for quality of care. Warne describes the philosophy behind the changes:

The concept of multiprofessional, multi-agency working underpins the White Paper proposals to make primary care services the driving force in the commissioning and provision of health care. The White Paper proposed changes to the organization and structure of the NHS in order to ensure this is achieved. The structural changes are focused on the creation of PCGs and include the development of new combined GP fundholding practices and community trusts and greater collaboration between primary and secondary services and other social welfare services, responding to locality populations of approximately 100,000 people. (1998, 8)

Reform of the system related to primary care will build upon existing configurations of GP fundholders and community trusts, responsive to local needs. PCGs are designed to cover populations on a regional basis, with the goal of reducing transaction costs, inequity of patient services and fragmentation of planning. At the most comprehensive level of development, PCGs will be established as free standing trusts accountable to the Health Authority for commissioning care and providing community care for their patient populations.

Other key developments include the implementation of comprehensive "Health Improvement Plans" to establish a framework for health care for each area and population covered by a PCG, and including inter-organizational and sectoral input as well as, in some cases, the creation of multi-agency "Health Action Zones to reduce health inequalities and increase health improvements through partnership initiatives" (9). Policy-makers also developed a new set of roles and relationships for health care providers, including a "leadership role for nurses" in children's health care. As well, under the Primary Care Act, 1997, "non-medically-led combinations" of health care service provisions to communities are possible and a number of pilot projects – Primary Care Act Pilots – were implemented in April 1998. The projects offer new definitions and responsibilities for professional groups, including nurses who will lead many of the community-based services to provide general medical care. The Act encourages innovation to ensure that health needs are met, in terms of both the locality and the extension of care to groups whose needs are unmet, and that the delivery of primary and community care are well-integrated.

## **6.2 Primary Care Reform in the US**

In his description of primary care reform in the US, Robert Hodge (1994, 15) writes: "The current health reform movement has placed a major responsibility on primary care to solve

*"The current health reform movement has placed a major responsibility on primary care to solve many of the problems in health care delivery today, such as costs, utilization, and prevention."*

many of the problems in health care delivery today, such as costs, utilization, and prevention" (15). In the US, primary care physicians work in fee-for-service private practice and in organizational settings such as multispecialty group practices, Health Maintenance Organizations (HMOs), and hospitals. As the emphasis on primary care grows, there is a demand for primary care physicians. In particular, HMOs and other managed-care organizations need more GPs to act as the first point of contact with the system and to "serve as gatekeepers – physicians who channel and direct patients through their systems with due regard for costs" (Korcok 1994, 1850). In the US, there has been a move to capitation from fee-for-service funding for hospitals and payment for primary care providers. This method of funding and remuneration relates closely to the growing dominance of managed care, with an emphasis on primary care. Pallarito writes:

HMOs like capitation because it makes hospital and physician costs more predictable. Health care CFOs (Chief Financial Officers) like it because they can manage their costs against the agreed-upon, per-member, per-month payment. Prepayment avoids niggling accounts-receivable collection delays and reduces bad debt. (1994; 94)

The increasing recognition of primary care physicians is linked not only to the demands of managed care but also to the historically low level of development of primary care in the US system relative to other countries. Many Americans use specialists as their first point of access to the health care system. Commentators note that this "poor development" has received relatively little attention historically "despite evidence that it may underlie or at least exacerbate access, quality and cost problems" (Starfield and Simpson 1993, 3136). Starfield and Simpson point to the advantages of primary care for the American system, in particular that it is less expensive than specialist care, which tends to be highly utilized in the US, and less focused on high-tech treatment. Still, they recognize the paradox that primary care reform efforts are directed toward the goal of achieving greater accessibility while "[m]anaged care arrangements in the US are primarily focused on reducing access to certain types of services rather than encouraging provision of useful service" (Starfield and Simpson 1993, 3136). There are a number of proposals to increase the practice of primary care medicine, including physician training, encouragement of primary care through restructuring of remuneration schedules and mechanisms, bonus payments for team practices and high levels of primary care service, and support for research in primary care. Indeed, one of the central problems facing efforts to increase primary care services is a shortage of primary-care physicians trained and practicing in the US (Korcok 1949, 1849). Managed care organizations feature a 50:50 ratio of primary care providers and specialist physicians, a much higher proportion of primary care physicians than exists in the physician population generally (O'Connor et al. 1998, 62).

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### 6.3 Primary Care Reform in Canada

In Canada, with the exception of salaried physicians working in Community Health Centres, physicians working in Centre locaux des services communautaires (CLCSs) in Quebec, and physicians in remote areas compensated by alternative payment plans, most primary care is provided by physicians who are paid on a fee-for-service-basis. In Ontario, Health Service Organizations were the first to use payment by capitation but pilot projects in other provinces are now underway.

Indeed, primary care reform has featured as a priority on the agendas of the federal government, provincial governments, regional health authorities, and medical associations in Canada. In a 1998 speech, the federal Associate Deputy Minister of Health Alan Nymark noted that addressing needs in primary care and improving the integration of service delivery are the essential federal government priorities for maintaining and strengthening the health care system. As part of the Health Transition Fund, established in 1997, the federal government has provided more than \$100 million to the provinces for the implementation of primary health care pilot projects, as well as evaluation and dissemination of learning. The first provincial project under the Health Transition Fund was the Alberta Primary Health Care Project worth \$11 million.

Primary care reform was also the subject of an influential discussion document by the Federal/Provincial/Territorial Advisory Committee on Health Services in 1995 entitled, "The Victoria Report on Physician Remuneration: A model for the reorganization of primary care and the introduction of population-based funding." The report described the current fee-for-service system as "fragmented and disorganized" and called for change in physician remuneration methods as well as reorganization of primary care service delivery (1995, 8). The report proposed a greater emphasis and focus of resources on primary care in the health system and argued that primary care should be funded according to population needs rather than on an episodic (fee-for-service) basis. Such changes to the system were expected to reduce spending in other areas by reducing hospital stays, diagnostic tests and prescription-drug use.

The report proposed funding based on a capitation system linked to population health needs (measured in terms of the number and characteristics of patients served) and rostering of patients. In order to achieve greater integration of services, it also proposed organizational changes including group practice with multidisciplinary teams, clinical care protocols, and accountability of primary care organizations to governments through contracts and performance indicators. Primary care organizations would provide, at the very least, care for episodic illness and injury, care for chronic illness, management and

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coordination of comprehensive care, preventive care, patient advocacy and patient education. At higher stages of development, primary care organizations could also contract with health authorities to provide more specialized care to the community, including obstetrical or hospital care. Primary care organizations could also manage budgets to purchase defined services and pharmaceuticals for their patient populations. Such increased responsibility is designed to encourage "more efficient and higher quality of use" of diagnostic and other services accessed by referral from a family physician (1995, 19). The primary care organization would reinvest any surplus portions of their purchasing budget to enhance services and infrastructure in the organization.

This proposal also addressed the challenges of providing primary care in rural and remote areas. A model for dispersed practices in such areas includes the formation of "management groups" to generate electronic record keeping, quality improvement activities, and, where reasonable, on-call coverage. The proposal includes payment of financial incentives for the formation of group practices, and achievement of health care objectives for the patient population (e.g., for specified rates of coverage for immunization and screening tests) (1995, 14-17). The system of capitation funding and other allowances would serve to ensure provision of primary care for rural and remote regions.

The College of Family Physicians of Canada (CFPC), the national voluntary medical organization, which sets the standards for the practice of family medicine and the education of family physicians, has also weighed in on the primary care reform issue. The College proposed a model for reform based on Family Physician Networks (FPN) (Gutkin 1997, 38). Primary care is central to the reform, with family medicine practices as the vehicles for the management and delivery of primary care services, and with the encouragement and promotion of multi-disciplinary teams. As with the Canadian Medical Association, the CFPC calls for "maximum flexibility in how family physicians are compensated" (Gutkin 1997, 38).

The CFPC supports a blended funding mechanism with a range of remuneration options – salary, fee-for-service, capitation – to enable flexibility in funding and payment:

We think this flexibility is important because the preferred payment mechanism should be dictated by the practice setting. Since patients and their needs vary widely, the practices of physicians will vary as well. This diversity must be reflected in how doctors are compensated. (Gutkin 1997, 40)

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mechanisms,  
information  
technology systems,  
patient education  
and behaviour,  
quality assurance  
measures, and  
evaluation  
procedures.*

movement began in Saskatchewan in 1962 and CHCs have an important presence in that province, although there are relatively few CHCs in the provinces outside Ontario and Quebec. In Ontario, there are more than 100 CHCs and Health Service Organizations, and, in Quebec, 160 CLSCs have the capacity to deliver health and social services to the whole population (Lepnurm 1995, 40).

CHCs offer care provided by teams of health professionals working in an accessible site in the community. The health centers offer a range of services that are closely coordinated with social services and related community services, with the goal of enabling individuals, families, and the communities in which they are situated to overcome a range of problems. The principles that underlie CHCs include a community-oriented, holistic approach to health with emphasis on disease prevention and patient education. Most CHCs are funded by capitation or program-based budgets, and staff are paid by salary.

Community Health Centers have a strong record in delivering primary health care, including assessment, diagnosis, and treatment services. CHCs can offer substantial economic benefits as well. For example, controlled studies in places such as Saskatoon have shown that they are less expensive than fee-for-service practitioners, with no compromise in quality of care. CHCs also enable the integration of health services with other social service agencies, reflecting a model of health that includes multiple social, cultural and economic determinants (Manga 1998, 490).

As this section shows, primary care is a vital element of national health systems and the focus of reform in the UK, US, and Canada. The appendix provides a road map of primary care reform projects in the Canadian provinces, demonstrating the prominence of primary care reform on policy agendas and its potential to change the organization and delivery of health care services.

## **7. Conclusions and Future Directions**

Primary care reform is a complex and multifaceted process with many dimensions of change including models of service delivery, physician payment mechanisms, information technology systems, patient education and behaviour, quality assurance measures, and evaluation procedures. There are various levels of analysis that can be applied to understand the impact of reform: micro (individual behaviour, including the roles and responsibility of practitioners, patient behaviour); meso (practice models, governance including the relationship and contracts between practitioners, regional health authorities, medical associations, provincial ministries); and macro (broad changes in the areas of costs for care, system wide changes in patterns of service delivery and utilization, population

health status). Evaluations will generate multiple layers of information. Thus, clinicians and clinical analysts might be most interested in rates of screening for disease, attendance at health education and health promotion sessions, health management rules in primary care practice, roles and responsibilities of physicians and other providers, contracts and accountability, and population health outcomes. Policy-makers might focus on broader issues such as costs for care, budgets, risks, project costs and processes of implementation, decision-making processes with stakeholders, and quality management and population health outcomes.

Research indicates that primary health care reform initiatives are a response to different issues and demands in different environments, often linked to larger restructuring in organization and funding levels by the provincial governments. There are high levels of support for the importance of promoting and expanding primary health care service in the health system. As well, there is a recognition that optimizing primary health services includes integrating the services of a number of health care providers and practitioners engaged in health promotion and prevention. In some cases, reform involves working more closely with other social and community agencies, reflecting the influence of socio-economic and cultural determinants on the health status of individuals and populations.

In Canada, most reform initiatives are umbrellas for a number of pilot projects in various geographic areas – suburban, inner city, small town, rural – and serving different populations, e.g., high proportion of elderly persons, high proportion of young families, high proportion of people who lack permanent housing or are homeless. Although reform projects are based on general models, these models must have sufficient flexibility so that specific projects can reflect the particular environment and population needs. For instance, the 8th and 8th Clinic in Calgary was established to respond to particular needs in the inner city in the absence of a hospital located within the downtown core. However, it is important to note that while particular pilot projects must be understood in the context of their environment, such environments are shared within and across the provinces, creating an opportunity for intra- and inter-provincial learning.

Rigorous, long-term evaluation of such projects is critical, leading to information that is important for future decision-making regarding physician training and distribution, delivery of primary care services, physician and patient behaviour, and health outcomes. The development of these models, and the information that could be made available based on the evaluation, have the potential to significantly affect health policy and health care funding in the provinces and to contribute knowledge to the Canada-wide health policy field.

Taking a step back from the actual nuts-and-bolts of reform, a set of questions arises related

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to the processes of designing and implementing reform models and pilot projects. The literature suggests that successful reform projects face a number of challenges. Project leaders require a great deal of high-quality information, often including consultation with experts who are experienced in the process. The process of reform includes complicated planning, budgeting, and decision-making procedures for reaching consensus amongst a number of stakeholders, in particular the practitioners involved, the regional or district health authority, the medical association and the provincial ministry of health. There are significant costs involved in terms of time and resources for these procedural tasks. Such costs are added to infrastructural changes, in particular related to the purchase and implementation of new information technology systems.

Important questions arise that are related to these processes. How are governments, regional health authorities and practitioners meeting these challenges? What are the overall costs involved in health care reform initiatives in Canada? How many projects have the kinds of quality assurance measures and rigorous evaluation necessary to enable conclusions about the impact of initiatives on health outcomes? What are the gaps in information that need to be filled?

In order to answer these questions, it would be worthwhile to undertake a survey of leading practitioners and other actors involved in the pilot projects in one or more provinces to determine such things as:

- in the environment of change and learning, what are the costs involved in health care reform initiatives?
- what are the channels through which information and evaluations are shared and communicated at all levels of the process (macro, meso, micro) and is there ease of communication? Is there sufficient exchange of information and learning?
- is necessary information available and easily accessible?
- what is the availability and cost of consultants?
- what are the recommendations for co-ordination of information?
- what measures are incorporated into the project to evaluate the project, and to disseminate the information, making data available to other practices and analysts?

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- what problems were encountered, especially with regard to budgeting, decision-making, and implementation?

This research would contribute information on such policy-relevant issues as: costs of projects and transitions, recommendations and costs regarding information technology systems, administration and decision-making procedures in reform, and information dissemination strategies.

Organizational reforms alone are not sufficient to improve health outcomes, cost for care, and other dimensions of health services (Hurley et al. 1999). Other critical factors are a high level of commitment to values inherent in the reformed service delivery and funding models and changes in attitudes and behaviour among physicians, other providers, and patients. This change is cultural, measured by quality assurance and evaluation, and is critical to successful outcomes and attainment of objectives. Information and education about the objectives and implementation of primary care reform for patients is important to ensure understanding of the changes and enable patients to fully access available services for advice and treatment as needed (Canadian Health Services Research Foundation, 1999).

In Canada and other countries, primary health care reform, and reform of the health system more generally, is an important issue on the public policy agenda. The policy environment is open to change and innovation, and in this environment there are many reform initiatives. A significant body of literature on health care reform argues or assumes that changes should be consistent with the prevailing philosophy that underlies the national health system. In Canada, such principles are embodied in the Canada Health Act. Generally, countries face the shared challenge of reforming their respective national health systems while preserving the most valued elements (O'Connor et al. 1998, 63). Health care reform is driven not only by economic, organizational, and service delivery concerns but also by an awareness of the relationship between health care policy and larger public values. ■

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## Notes

1. The Canada Health Act establishes the framework of principles for the health care system. These principles are: universality, accessibility, portability, comprehensiveness and public administration.
2. See Hutchison and Abeison 1996; Manga 1998; and McArthur et al. 1996 for further discussion.
3. Health care costs reflect the prices attached to various services and treatments while health care spending reflects the total number of dollars devoted to health care.
4. For instance, Canadians have significant freedom to choose their primary care doctor.
5. In Canada, rostering would not "lock-in" patients for lengthy periods of time, upholding the principle of patient choice of practitioner that is in keeping with the principles of accessibility and portability in the Canada Health Act.



**Appendix:**  
**Primary Care Reform in Canada:**  
**A Selection of Federal, Territorial, and Provincial Projects**

	<b>Federal Government</b>	<b>Yukon</b>	<b>NWT</b>
<b>Project</b>	Health Transition Fund	Primary Care Delivery in Remote Communities	Focus on Primary Care in Communities
<b>Overview</b>	The Health Transition Fund was established by the federal government in 1997 to fund research on the organization, funding and delivery of health care services in four priority areas: primary health care, pharmacare, home care, and integrated service delivery.	Yukon government establishes legal framework to enable nurses in communities to take on expanded primary care role.	Strategic plan includes development of a primary care model that emphasizes health promotion and integration of services in communities.
<b>Actors</b>	Department of Health; Territorial and Provincial Ministries of Health.	Yukon Ministry of Health and Social Services; Yukon Medical Association; physicians and nurses.	NWT Ministry of Health and Social Services; physicians and other health care providers.
<b>Objectives</b>	The Health Transition Fund was a response to the National Forum on Health, which recommended that the federal government support the development of greater integration of health services.	Ensure primary care services available in remote communities.	Emphasize service delivery to fill community needs.
<b>Description</b>	The Health Transition Fund provides \$150 million to support the implementation and evaluation of pilot projects which reflect the objectives of the project. All projects have an evaluation component and some common evaluation criteria is used for all projects. The Fund is also used to hold national conferences in order to encourage the exchange of information and identify ideas for future pilot projects.	In one primary care model, a physician has been contracted to provide services in conjunction with nursing station staff providing primary care in an expanded role. There are plans to implement this model in other communities.	Primary care model emphasizes health promotion and education including greater co-ordination of health and related social and community services.



**Appendix Continued:**  
**Primary Care Reform in Canada:**  
**A Selection of Federal, Territorial, and Provincial Projects**

	<b>British Columbia</b>	<b>British Columbia</b>	<b>Alberta</b>
<b>Project</b>	Primary Care Demonstration Project	Comox Valley Nursing Centre Demonstration Project	Advancing Primary Health Care in Alberta
<b>Overview</b>	Three-year, \$26 million project at seven primary care practices across the province, with the addition of ten community health care sites over three years.	Two-year (1993-1995) demonstration project designed to promote primary care, in particular to evaluate the role of nursing services in primary health care.	Twenty-seven pilot projects established in 1998 to implement and evaluate various models of primary care services. Health Transition Fund contributes \$11 million over two years.
<b>Actors</b>	B.C. Ministry of Health; Federal Health Transition Fund; B.C. Medical Association; physicians and other primary care providers.	Registered Nurses Association of B.C.; B.C. Ministry of Health; other health agencies.	Alberta Health and Wellness; Health Transition Fund; Alberta Medical Association; physicians and other primary care providers.
<b>Objectives</b>	Evaluate models of service delivery to improve co-ordination and integration of patient care; Emphasize health promotion and illness prevention; Provide multi-disciplinary care; Implement clinical information management systems.	Increase coordination and integration of health care services; Emphasize patient education; Address social determinants of health; Provide effective nursing care.	Enhance and evaluate ongoing primary care pilot projects and implement and evaluate new primary care pilot projects; Emphasize improvements in the delivery of primary care including collaboration between various providers; Focus on disease and injury prevention and health promotion; Address multiple determinants of health; Generate lessons for providers and policymakers for future decision-making and disseminate information to other jurisdictions.
<b>Description</b>	Primary care demonstration projects include capitation funding, according either to geographic or demographic population factors. A wide range of services will be offered at demonstration sites by physicians, nurses, nutritionists, social workers, and physiotherapists.	The project demonstrated and evaluated an alternate system of primary care delivery, focused on the Nursing Centre as the point of entry into the system and providing care in a multi-disciplinary setting. A coordinator and two full time nurses provide a number of primary care services to enhance the existing primary care sector, including support groups and integration of services with other agencies in areas such as youth health, women's health, heart health and chronic illness. Evaluation supports the establishment of multi-disciplinary community health centres and collaborative primary care practices.	There are a number of pilot projects in Alberta including: <i>Calgary Region:</i> Evaluation of the Alexandra Community Health Centre; Enhancement of Primary Care of Palliative Cancer Patients; Shared Mental Health Care in Primary Care Practice. <i>Capital Region:</i> Healthy Families Primary Health Care Services to High Risk Families; Misericordia Health-Lifestyle Improvement Education Centre; Evaluation of Edmonton Centre for Survivors of Torture and Trauma. <i>Keeweenaw Lakes Region:</i> Evaluation of the Usefulness of Telehealth in Providing Advanced Primary Health Services to Northern, Remote Communities.



**Appendix Continued:**  
**Primary Care Reform in Canada:**  
**A Selection of Federal, Territorial, and Provincial Projects**

	<b>Alberta</b>	<b>Saskatchewan</b>	<b>Manitoba</b>
<b>Project</b>	Tripartite Pilot Projects	Primary Health Services Initiative	Primary Care Health Unit established in the Department of Health
<b>Overview</b>	Implementation of various pilot projects to test alternative service delivery and funding models.	The Government of Saskatchewan is promoting a model of primary health care delivery at various sites, emphasizing a coordinated team approach to the delivery of services and integration with other social and community services.	The Unit supports the development of primary care reform models and demonstration sites.
<b>Actors</b>	Alberta Medical Association; Alberta Health and Wellness; Regional Health Authorities; physicians and other primary care providers.	Saskatchewan Health; District Health Boards; physicians and other providers.	Manitoba Health; Manitoba Medical Association; physicians and other providers.
<b>Objectives</b>	Joint effort initiated in 1997 to examine and test new service delivery models and alternative funding and physician payment mechanisms.	Promote more integrated primary care service delivery in order to improve health outcomes. Demonstration sites emphasize a team approach to service delivery with greater integration of physician services with the work of other primary care providers and emphasis on illness prevention and early treatment, especially for people at high risk for poor health. Primary care practices may develop outreach programs in collaboration with other social agencies and public health services in communities.	Reform focuses on alternative funding models, the development of multidisciplinary practices, and implementation of information technology systems.
<b>Description</b>	Six projects initiated and more will be developed under the auspices of the Alternate Payment Plan, which replaced the Tripartite process in 1998. Projects include Bassano Community Health Centre, Northeast Community Health Centre in Edmonton, New Directions in Family Practice: A Study of Alternative Funding Mechanisms for Alberta Family Physicians.	Sites are being developed in large and smaller urban areas, rural communities, and remote communities. Several sites are targeted to particular populations, including inner-city residents, aboriginal peoples, and seniors. There are options for alternative payment plans for physicians to provide remuneration for services not covered by the fee schedule. In rural areas, where it is difficult to recruit physicians, the inclusion of a primary care nurse at demonstration sites enhances the quality of life for physicians. Nurses can be on first call with physician back-up by telephone, providing relief to physicians. Evaluation is ongoing.	Primary care pilot projects are underway. In addition to these new projects, there is an ongoing model of Community Nurse Resources Centres established in inner-city Winnipeg, northern and rural Manitoba to provide primary care services as well as education and outreach.



**Appendix Continued:**  
**Primary Care Reform in Canada:**  
**A Selection of Federal, Territorial, and Provincial Projects**

	<b>Ontario</b>	<b>Quebec</b>	<b>New Brunswick</b>
<b>Project</b>	Primary care reform is ongoing.	The Ministère de la Santé et des services sociaux has established the further development of integrated service delivery as a priority in Quebec.	Shared Care Model
<b>Overview</b>	In Ontario, primary care reform projects have operated since the 1970s when the government introduced Community Health Centres with global budgets and community-based boards. Later Health Services Organizations (HSOs) were introduced with capitated funding. Alternative payment plans and alternative funding plans have been introduced, particularly in teaching hospitals. Nurse practitioners and midwives are active in primary care service delivery (Williams and Lloyd 1997, 62).	The Ministère de la Santé et des services sociaux du Québec has established the further development of integrated service delivery in response to the needs of local populations as a priority in Quebec.	Expanded roles for nurses implemented in Community Health Centres.
<b>Actors</b>	Ministry of Health; Ontario Medical Association; Health Transition Fund; physicians and other primary care providers.	Ministère de la Santé et des services sociaux; community agencies; physicians and other providers.	Department of Health; New Brunswick Medical Association; physicians and nurses.
<b>Objectives</b>	The goals of the most recent reform pilot projects are to improve continuity of care, enhance health prevention services, and providing comprehensive care on a round-the-clock basis.	Reflect the goal of coordination between health and social services agencies, including CLSCs, community agencies, and long-term care facilities.	Enable optimal use of the various skills of health professionals, in particular nurses and physicians, although the model could be expanded to include other primary care providers.
<b>Description</b>	The most current announcement regarding primary care reform projects was made in Sept. 1999 when three sites were added to four (announced in May 1998) in which networks of primary care physicians (not necessarily at the same site) are providing comprehensive care through extended office hours, after-hours telephone advice from a registered nurse, and implementation of information technology systems to upgrade patient records. The projects include voluntary patient enrolment and a capitation funding formula (now used by 77 Health Service Organizations in Ontario). The sites are situated in two Northern communities and a large urban centre, among other places. Decisions about expansion into other communities will include evaluation of the existing projects.	The province has a long history of integration of primary care health services with other social and community services. Currently, a number of pilot projects supported by the Health Transition Fund are underway. These pilot projects reflect a variety of initiatives, including improvement of health promotion and disease prevention services, integrated care, using capitation funding based on the needs the local populations, and implementation of computerized clinical information systems.	Nurses take on an expanded role in Community Health Centres. In October, 1999, pilot projects were initiated in urban and rural family practices to evaluate the benefits of collaboration between physicians and nurses in primary care practices.



**Appendix Continued:**  
**Primary Care Reform in Canada:**  
**A Selection of Federal, Territorial, and Provincial Projects**

	<b>Nova Scotia</b>	<b>PEI</b>	<b>Newfoundland and Labrador</b>
<b>Project</b>	Strengthening Primary Care in Nova Scotia	Family Practice Demonstration Site	Primary Health Care Enhancement Pilot Project
<b>Overview</b>	In 1999, demonstration sites were established to test new primary care service delivery models, support by \$28 million from the Health Transition Fund.	The project was designed to introduce and evaluate a comprehensive-care service delivery model in primary care practices.	The project was established in 1997 with support from the Health Transition Fund.
<b>Actors</b>	Department of Health; Health Transition Fund; physicians and other primary care providers.	Department of Health and Social Services; Medical Society of PEI; physicians and nurses.	Department of Health and Community Services; Health Transition Fund; physicians and other primary care providers.
<b>Objectives</b>	Evaluate four dimensions of primary care reform: the support available to primary care providers embarking on new models of service delivery; the role of nurse practitioners in primary care teams; the impact of a different funding and payment mechanisms for providers; the effect of new primary care models on the delivery of health promotion and illness prevention services.	Evaluate the application of collaborative practice principles and to determine the effect of the change in the physician and nurse roles on patient satisfaction, roles and responsibilities of physicians and nurses, health outcomes for patients, utilization of services, and practice costs.	Establish interdisciplinary primary care services and teaching units in three sites in the rural areas of the province in order to evaluate the potential for advancing recruitment and retention of health professionals in rural areas by providing opportunities for research and teaching as well as the delivery of primary care services. Ensure health care services are responsive to the needs of the local populations.
<b>Description</b>	In order to qualify for inclusion in the project, primary care practices must include a nurse practitioner practicing collaboratively with one or more family physicians and other members of the interdisciplinary primary care team; alternative payment mechanisms for primary care providers; information technology systems to support primary care services delivery; evaluation of the project.	The project was implemented for two patient groups: patients with diabetes and seniors. The service delivery goal for diabetic patients was to effectively monitor management of patient care and to develop clinical practice guidelines for collaborative care. The service delivery goal for seniors was to meet particular needs for advice and information by using non-physician providers including other community-based services. Over the course of the project, successful collaborative practice was used to manage other patients with complicated health needs who were not in the target groups.	The pilot projects will include teams of physicians working collaboratively with nurse practitioners and other health professionals. In addition to primary care services, the teams will undertake research and teaching in primary care. The project includes nurse practitioners who are an important part of primary care services in rural areas in the province.



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